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CLINICAL LECTURES.

CIRCUMCISION FOR CONCEALED CHANCROIDS.—ENUCLEATION OF ADENOID TUMOR OF GROIN.—INTERNAL URETHROTOMY.¹

BY JOHN B. DEAVER, M. D.,

PHILADELPHIA.

Circumcision for Concealed Chancroids.

Gentlemen: The first case I have to show you is one of great interest. The patient has had both chancroids and gonorrhoea. He comes now before us with a penis which is greatly swollen. He says this is the third time it has been in this condition; the first, two years ago, and the second, last winter. Each attack lasted three or four months. His present attack started with a chill one

morning last month. Two hours later his penis and scrotum became very heavy and cedematous, and have remained so ever since. I do not know how long he has been in the venereal wards, but for three weeks at least. He has a very long prepuce which is adherent to the glans penis. The swelling of the scrotum appears, at first sight, very much like elephantiasis, which is, as you know, a diseased condition of the connective tissue and lymphatic vessels. When I saw him the first time I divided the swollen prepuce along its dorsal aspect, but with only partial relief. Not feeling satisfied, I told him a day or two since that I would etherize him and make a thorough exploration of the parts. To this he agreed, and to-day I have brought him before you for this purpose.

This cedematous condition may be due to an inflammation of the mucous covering of the glans (balanitis), or to the mucous lining of the prepuce (prothitis), or to a combination of the two (balano-prothitis). It may

¹ Delivered at the Philadelphia Hospital.

hernia. I shall proceed to dissect it out. I make my incision in the line of Poupart's ligament, dissecting off the fascia with the scalpel. You now notice that I am enucleating the tumor, keeping my knife close to the tumor itself while cutting the bands of fascia. This is a very simple procedure as long as you follow this rule. Having enucleated the growth I cut it open, when it is very evident that it is glandular structure. I have exposed the saphenous opening, also the aponeurosis of the external oblique muscle. I have, at this aponeurosis, not opened up the inguinal canal. I tie all the bleeding points with catgut, introduce a rubber drainage-tube and bring the edges of the wound together with interrupted silver-wire sutures. The wound is dressed antiseptically, and the thigh flexed slightly upon the abdomen, in which position it will be kept till union is complete.

This, in my judgment, is the proper course to pursue in all growths of this character, and not to waste time in attempting to remove them by local applications, or to allow them to break down and form abscesses—which latter often leave sinuses for the ultimate cure of which it will be necessary to lay the parts open, and to remove the remaining degenerated gland structure.

Internal Urethrotomy.

The next patient I bring before you is one on whom I expect to do an internal urethrotomy. I cannot show you too many of these cases of stricture. This man had a chance seven years ago. He had gonorrhoea three years ago; the discharge continuing four or five weeks, for which he never did anything—a very important point. If left alone cases of gonorrhoea do infinitely better than where doctored with strong astringent injections, and sandal-wood, copaiba and the other drugs used for this purpose. Under the above treatment, if you obtain a cure in a case of gonorrhoea in say ten weeks you have cause to be congratulated.

Three months ago he first noticed trouble in passing urine; he had at this time retention. Micturition now is not painful, but it is frequent, and but little urine is passed at a time. I have already told you that a stricture which will produce retention is often one of small but of large calibre. A study of the anatomy of the urethral canal will explain the reason for this. It is largely supplied with nerves from the hypogastric plexus of the sympathetic system, also from

the spiral system of nerves, and as a result, sympathetic constriction is often produced by a small lesion. This is the rationale of these cases of retention occurring where there is a stricture of large calibre. Of course this is not true in every case of retention, but it must be borne in mind.

There are some abrasions here on the glands, the result of irritation produced by the discharge of urine, which is ammoniacal. Every urethra has an individuality, and there is a proportionate relation between the size of the urethra and the size of the penis. This organ measures three and one-quarter inches in circumference, corresponding to a urethra with a calibre of 32 millimeters. The orifice of the urethra here is very small and does not admit this urethral-meter, which is 20 millimeters in circumference. The first step in the operation is to divide the meatus, which I do with the meatotome, making the incision along the floor of the urethra and enlarging it to 32 millimeters, the normal character of the canal as determined by measurement. In some cases the calibre of the urethra is larger than that indicated by the circumference of the penis, this being demonstrated by the urethral-meter.

I next carry the urethral-meter, closed, down to the bulbo-membranous junction, which you see I do readily. I now dilate it to 32, the size learned by measurement, when I find it glides to and fro very easily; I therefore expand it by turning the screw at the end of the instrument, until I meet with the slightest amount of resistance, with the penis well elongated, when I look at the dial and find that the hand thereon marks 34, the full calibre of this urethra. I now withdraw the instrument slowly and do not meet with any resistance till I reach this point, $2\frac{3}{4}$ inches within the meatus, where I find a stricture, the calibre of which I learn also by turning the screw, the hand on the dial thus diminishing the size of the bulb of the meter, and allowing it to be drawn through. The contraction is 32. This canal is trespassing upon at this point to the extent of 2 millimeters, in other words we have here a stricture of large calibre. Having passed beyond this point of contraction, I again screw the instrument up to 34, the normal calibre, when it glides along the remaining portion of the urethra without meeting with any resistance till I reach the meatus, where it is arrested; I having only enlarged this to 32, therefore I divide it again, making it 34

millimeters in circumference ; in this manner you see I have restored the urethra to its normal calibre. It now remains for me to divide the stricture with the urethrotome ; this operation you have seen me do many times and with most gratifying results.

ATAXIC PARA-PARESIS, ETC.

BY HENRY M. LYMAN, M. D.,
CHICAGO, ILLINOIS.

**PROFESSOR OF PHYSIOLOGY AND DISEASES OF THE
NERVOUS SYSTEM IN RUSH MEDICAL COLLEGE, .
CHICAGO.**

Gentlemen: This patient is sixty years old, and his occupation is that of finishing furniture. Two years ago he began to have pains in different parts of the body, which have continued to the present time. At night, when he walks about, he is unable to maintain his balance. He says that he takes a glass of beer occasionally, but no whiskey. There is inability to stand with the eyes shut. There is exaggerated patellar-tendon reflex, paresis of the ocular muscles, some disturbance of sensation, and a slight ankle clonus on the right side. What is more conspicuous to the patient is a feeling as if the legs were going to jerk, making it difficult for him to use them when he wants to.

What is the diagnosis? One gentleman says: "Inflammation of the lateral columns of the cord." It is not exactly an inflammation. Would it not be better to say that there is a *degeneration* of the lateral columns of the cord? We have none of the symptoms of inflammation, but there are symptoms of degeneration, and the degenerative process has involved the lateral columns of the cord. What shall we call this disease? Descending degeneration? No. Descending degeneration starts from some lesion, such as a hemorrhagic clot in the brain; but there is no evidence or history of that in this case. What disease would you call this, if the patellar-tendon reflexes were absent and the patient complained of lancinating pains, with a disturbance of innervation about the eyes, such as you now observe? You would call it locomotor ataxia, would you not? And what symptom is needed to complete the picture of locomotor ataxia? Loss of patellar-tendon reflex. Instead of that we have an exaggerated reflex. That seems to be the only thing by which we may differ-

entiate this disease from ordinary locomotor ataxia or tabes dorsalis. Dr. Gowers, and others who follow his teachings, consider it a disease by itself, and give it the name of ataxic paraplegia. It is ataxic, as was evident when the patient tried to balance himself. It is not exactly a paraplegia. That is a term which is not exactly appropriate here, and which should be confined to those cases in which there is complete loss of power. We might call it *ataxic para-paresis*, and this term answers well for that class of ataxic cases in which there is apparently a chronic weakness in the lower extremities, increased knee jerk, etc. We have no history of syphilitic infection in this case. You know that the majority of cases of locomotor ataxia follow syphilitic infection, but in cases of ataxic paraplegia, so-called, syphilitic infection is often absent. There seems to be that difference. Perhaps we shall have occasion to modify that statement in the future, but so far as statistics go at present, that seems to constitute one of the differences between the two disorders.

You remember that the seat of the disease in locomotor ataxia is in the posterior columns of the cord. Its seat in this case is to some extent in the posterior columns of the cord, but principally in the lateral columns of the cord. It is a disorder apparently in which there is a tendency to generalization of the degeneration through the pyramidal tracts of the cord, and to invasion of the posterior columns. If the disease happens to strike the central portions, near the median fissure, remote from the posterior nerve roots, then the patient does not complain of much pain. If, however, the nerve roots are encroached upon, he complains of pain, as in cases of locomotor ataxia. There are many grades of the disease; they run into one another. No two cases are alike, so that the pictures presented by the victims of chronic sclerosis or degeneration of the columns of the cord resemble one another very much, and at the same time differ considerably from each other.

The course of this disease and the treatment are identical with what has been considered under the head of tabes dorsalis.

Secondary Idiocy.

The next patient I show you is a little girl eight years old. She has some disturbance of the brain. A few weeks after birth she had an attack of scarlet fever. She recovered from the scarlet fever and

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The part of the brain attacked by the disease is enough to cause seven months of serious disability, sometimes a partial paralysis. It should be noted that the neglected work of development is short, we are lowering an average of one of any kind that has been disease was the brain. Patients lose their cover the case of after symptoms and the feared, say itself, with resulting sanity.

Here was a case of diphtheria in the child, perfectly common, but which had been during the day, at night, mania. I have seen the day, I wake up in a crazy as a

afterwards seemed perfectly natural. She learned to walk and talk, and her father says she was quite "smart" until about two years ago last Christmas. Seven months before that time she had diphtheria, and began to lose her mind. Her urine dribbled away from her unnaturally.

The probabilities are that deterioration of the brain followed as a consequence of the attack of diphtheria, although it was not enough to be noticed until after some six or seven months had elapsed. You know how seriously diphtheria injures the nerves sometimes, causing in some instances muscular paralysis; and there is no reason why it should not occasionally involve other parts of the nervous system as well as those connected with the muscles. Its progress and development are slow and insidious. In short, we may have mental disturbance following any of the infectious diseases. That is one of the curious legacies that infection of any kind leaves to the system of a patient that has been affected. After any infectious disease we may have secondary lesions of the brain that may impair the mind. Patients after typhoid fever occasionally lose their minds, and may or may not recover them. This is notably true in the case of syphilitic patients. A long time after syphilitic infection has taken place, and the primary symptoms have all disappeared, syphilis of the brain may manifest itself, with evidences of disordered intellect, resulting in some instances in complete insanity.

Here we have a case of mental destruction, following, I have no doubt, the diphtheritic infection. We are told that the child has had no other symptoms of ill-health. She is strong, eats well, and is perfectly quiet at night. It is not an uncommon thing for patients whose minds have been damaged to be entirely disordered during the day, yet capable of rest or sleep at night. You see it in certain cases of mania. Such patients are violent through the day, but sleep quietly at night. They wake up in the morning and are as wild and crazy as ever.

I have asked the father in what way the mental disturbance has shown itself, and he says that she speedily gets out of patience, runs from one end of the room to the other, throws her head from one side to the other, then pounds the top of her head with her hand. When she is hungry she gets angry more easily than was formerly the case, and

sometimes cries, but as soon as she gets something to eat she is quiet.

There is no loss of muscular power in this case. The child is as strong as ever. Her gait is steady and apparently natural and she never falls. She runs around all day long.

We have here, then, a disease of the cortex of the brain. The intellectual organs of the brain are the ones that have suffered and these are very delicate. It is the most delicate structures that yield first; consequently the intellect is impaired before any of the lower functions which are common to the lower animals. We have a deterioration of the intellectual organs, reducing the patient to the level of the inferior animals. It is not a congenital condition, for if it were, we should call it idiocy. It is a secondary condition. So far as the future of the child is concerned, she is not likely to develop any further.

Unfortunately the treatment of such a case as this is exceedingly unsatisfactory. There is a defect in the intellectual organs of the patient, and we cannot put into the brain what is not there. If the condition were merely a lack of development there might be some hope for improvement, but where the intellectual organs have been injured or destroyed, the condition of the brain is analogous to that which is presented in the gray matter of the spinal cord in a case of polio-myelitis. A certain portion of the gray matter of the cord is lost, and it can never be replaced. So in the case of the brain of the patient before us. As there has been a destruction of what did exist, we have no means at our command of replacing it.

Neuralgic Headache.

Here is a man, 34 years old, who comes to us complaining of nervousness and "neuralgia," from which he has suffered for two or three years. The neuralgia commenced on the left side of the head, and extended down the left shoulder. He had received no injury at that time. Since then he has had venereal disease, but not before. He has never enjoyed good health, and while he has always been delicate, yet he has managed to get through each day's work, and has been able to work right along; never sick in bed. He is a shoemaker by occupation, accustomed to sitting and working on a bench. He left the shoemaking business and became a member of the police force. While on the police force his left

shoulder was dislocated and he has not felt well since. The pain in the head may last twelve hours or may disappear in half an hour. Its duration is irregular. During the past week he has lost his appetite altogether, his nourishment simply consisting of oranges. His bowels are regular; his tongue is white and rather anæmic.

I have seen during the last few weeks a good many persons who were suffering with pain such as this patient describes, evidently of a neuralgic character, and which is more likely to occur in persons previously debilitated, and in whom there is a predisposition to neuralgic disorders. I am rather inclined to consider it an evidence of the operation of the influenzal poison prevalent in the community. I have seen a good many people, who, while not completely affected with the ordinary catarrhal form of influenza, yet were extremely debilitated and suffered intense pain in the head and back, or in both places—pains of a neuralgic character, attended with great exhaustion and prostration, loss of appetite, lasting for a number of days, sometimes nausea and vomiting, with a catarrhal state of the intestines. All these are varieties of the influenza, and are due to infection with the influenzal poison; and I think it is not unlikely that this patient (although an old sufferer with neuralgia), from the symptoms he describes, the appearance of his tongue, the loathing of food, the prostration, etc., is one of the victims of influenza.

In such cases the best thing you can do is to wait a little time for the patient to recover. Six weeks may be requisite for recovery from the stage of exhaustion which these patients exhibit. Some of my medical friends have had an opportunity of personally testing this form of toxemia; and it is their universal testimony that they have experienced nothing so debilitating as the effects of this form of poison. I have observed in this and in previous epidemics that it takes no less than six weeks to recover from the debility thus produced. The nausea passes off in a few days and the appetite comes little by little. The ordinary tonics do very little good. I believe the taking of quinine in considerable quantities does no good. Doses of a single grain are preferable. Strychnine does very little good. The best thing is rest. The patient should take anodynes to relieve the pain, and anodynes containing opium are the best for these cases. Alcohol is an excellent thing

for patients you can trust with it, and may be freely used with advantage. These remedies must be used cautiously when making prescriptions for persons whom you do not know. My impression is that rest, opiates and alcohol are the most useful remedies in the treatment of cases in which the influenzal poison is operative. When you have passed the period of acute influenzal poisoning, then you may advise such general treatment as would be proper for a patient who is convalescent from other infectious diseases.

Neuralgic headache is a very obstinate disorder, and requires general treatment as much as it does paroxysmal treatment, the treatment for the paroxysm consisting principally in putting the patient to bed and giving anodynes. Usually patients find some particular anodyne that agrees with them better than any other. Opium is as useful as anything in these cases, especially when given in the form of chlorodyne.

Phenacetine, acetanilid, and antipyrin work well with some patients for awhile, and then they cease to benefit them. Where there is great nervous prostration, it is not advisable to give them often on account of their action upon the heart. Many persons have been injured for the time being, and their convalescence has been delayed by the excessive use of these drugs during the course of this recent influenzal epidemic.

For this man I would recommend taking twenty drops of chlorodyne, and repeating it every two or three hours until he is relieved. I would then commence the use of alcoholic stimulants. I told you the other day that many of the elixirs are useful in such cases. The compound elixir of gentian, or of cinchona for example, are good tonics, and they should be administered for two or three months, along with general hygienic care.

SCHOOL OF ANATOMY, TRINITY COLLEGE.—Arrangements have now been completed by which for the future the Anatomy School will be lighted by electricity. In the dissecting-room are fixed seventy-three incandescent lamps, each of twenty-five candle power, arranged in groups of four under enamelled shades. In the dynamo house are fixed an Otto gas-engine which supplies the motive power, and also two centrifugal pumps for raising the drainage of the College park twelve feet and discharging it into the city sewers.

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COMMUNICATIONS.

REPORT OF A CASE OF EXCISION
OF ENTIRE HUMERUS: OPERA-
TION IN THE PRESENCE OF
CHOREA MAJOR.¹BY J. C. SEXTON, M. D.,
RUSHVILLE, IND.

The case to which I would for a few moments invite your attention almost reports itself in the exhibition of the specimen. It is of very unusual surgical interest, owing to the importance of the structures involved and to the many and diverse aspects in which from date of injury to that of operation it presented; at the same time it is of no little medical interest from the fact that life was greatly endangered; not by the disease alone, but by a rare complication.

The history of the case is briefly the following: Thomas M., ten years old, was thrown on the ice and injured about the shoulder and right side in February, 1888. For a few days he suffered some pain and stiffness about the joint, which soon subsiding, little notice was taken of the accident. Not long after, the structures began to swell and arm and shoulder became tender and painful. Dr. Barnum, of Manilla, saw the case, and opened an abscess which pointed just below the deltoid insertion. Pain was relieved; a sinus followed, and later necrosis was discovered. I first saw the case on June 15. There was marked bone disease up to and involving the head of the humerus. About the shoulder and half-way down the arm the structures were all infiltrated. The bone itself at the middle third seemed enlarged, as if a callus were thrown out about it. There was, however, no history of fracture. Owing to the boy's condition of septic fever, loss of appetite, anemia, etc., as well as the excessive heat of the season, I declined to do any operation other than to excise and drain the tissue near the joint.

He was put upon tonics and his general condition improved so much that by the 15th of August he was able to visit me. Dr. M. Sexton was then consulted, and by his advice no operation was undertaken. The boy was kept quiet, and upon iron. His general condition continued fair for nearly a

month, when pain returned and he began to lose ground. By the first of October it was noticed that the patient was having peculiar twitching and jerking movements of the hand and arm. Gradually these movements increased, became quite violent, and caused pain. Other portions of the body became rapidly involved so that by the twenty-ninth—the date of operation—he was in a most deplorable state. He had a severe chorea, involving almost every movable part of the body, and with it the peculiar expression of countenance indicating imbecility; while every motion produced pain in the arm and the patient was rapidly sinking under the wear and tear.

As far as the family were concerned, they simply demanded that something be done to alleviate his condition and urged us not to amputate if possible. Drs. Spurrier, Barnum and myself talked the case over, and, as you may well imagine, were not a little doubtful what was best to do. An operation of magnitude in the presence of severe chorea was without precedent in the knowledge of any of us; while at the same time it was not to be expected, from the history of the case, that much good could come of treating the chorea with the arm in its present condition. Whether we accept the theory of reflex chorea or not, the waste and drain upon the vital organs in this profuse suppuration and pain would from debility alone keep up the chorea; which, you note, had come on right in the presence of and in spite of strong tonic medication.

We decided to excise the head and as much of the shaft as was diseased, thinking we could at least save the lower third. In operating I made an incision from the tip of the acromic process directly downward, on the outside of the arm, for six inches. The tissues were lifted from the bone and the head was pushed up into the incision. The capsular ligament was too dense to be cut with scissors, and this part of the dissection had to be done with the scalpel and chisel. Just below the middle of the shaft the bone appeared healthy, and it was sawed into at this point; but the condition of the medulla and Haversian spaces showed it to be diseased also; so that the incision was prolonged to the ulnar condyle; the elbow joint was opened and the entire bone was removed.

No further interest attaches to the operation itself, which was done under careful antiseptic precautions. Thorough drainage

¹ Read before the Union District Medical Society at Hamilton, O.

was provided for and antiseptic dressings were applied. The forearm was carried across the body and fastened immovably in that position. Under the anæsthetic the chorea of course ceased, and it did not return for three hours after he awakened.

Then it began, but not violently, was painless, and the laryngeal muscles were uninvolved, so that the boy could speak intelligently and without those facial grimaces that are so marked and so distressing. Within a week the chorea was almost well, and this without using the remedies usually depended upon; for, by mistake on the part of the nurses, the Fowler's solution that was ordered was given in such small doses that it could not possibly have effected so prompt a result. At the expiration of ten days the chorea was well. In thirty days the case was dismissed and the boy began to use the arm.

His present condition, February 8, 1889, is as follows: General health is perfect; no signs whatever of chorea; union perfect throughout the entire wound; no signs of bony growth.

From tip of acromium to olecranon: R. 6 in., L. 8 in.; circumference greater than on well side; motion of fingers perfect; grip firm but not so strong as other hand. Can lift to a good advantage, and carry a burden; can dress himself. No atrophy has taken place; but the muscles have not been used at all, as the nurse feared that the patient might injure himself.

The appearance of the boy is very good, as to the arm which he is able to hold in a natural and easy position, so that he does not present the aspect of a cripple.

Concerning an operation of such gravity in the presence of chorea, I can find no reference. A very few recorded cases have been brought forward of minor operation, such as removal of foreign bodies, division of nerve branches, etc., by gentlemen who hold the theory of reflex chorea to be tenable. Some cases are cited in Holmes's *Surgery*, Vol. IV. Of grave operation in this connection there is not a case recorded in any literature at my command.

True chorea in an otherwise healthy individual is extremely rare. It is even doubtful if it ever occurs without some predisposing prostration. So, to my mind, it is much more rational to look upon the debility incident to prolonged suppuration as productive of the disease, rather than to hold it due to reflex irritation. At the same

time, it must not be forgotten that the history of my case followed the rule of those cases supposed to demonstrate reflex chorea. It began in, and was for some time confined to, the arm; and, furthermore, it must be confessed that the anæsthetic, the shock of operation, the removal of local disease did, in some manner, exert a promptly curative effect upon the nervous phenomena. In what way this was accomplished I am not able to say. The effect of the anæsthetic in such cases is too well known for me to call attention to it here; but to credit etherization with the cure is a position that can hardly be maintained. It may not be out of place to speak of the unfavorable prognosis that attaches to chorea when dependent upon, or complicated by an injury. Most of you have, no doubt, noted the rapidly fatal termination of the case cited in the *American System of Medicine*, where an attack of chorea was complicated by a fracture of the humerus.

Excision of the entire humerus is an operation that is seldom performed. Coming, as it does, under the head of capital operation and being indicated so rarely, its place as surgical procedure is by no means fixed. The principal reasons that might be suggested for the rarity of the operation are: 1, that any lesion that calls for the removal of the entire bone comes within the indications for amputation at the shoulder joint; 2, because it has been stated by good authority that the mortality after amputation is less than after excision of the head with any considerable part of the shaft of the bone; and, 3, because it has been held that a flail-like arm is of no use whatever, and rather an incumbrance than otherwise.

On the other hand, it could well be maintained—at least for this particular case—that successful surgery is always good; that there may be bony regeneration of considerable amount; that the preservation of the form and outline of the member is much more slightly than an empty sleeve; that, on account of the shortening, thickening and consequent strengthening of the muscular tissues, no little degree of leverage will be preserved, and much valuable power of fingers, hand and wrist be retained.

I feel that one other word should be spoken here, before leaving the topic. I refer to action that is initiative and outside of recognized authoritative procedure. Circumstances not infrequently arise in course of practice when we are called upon to leave

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the beaten path, which, in a surgical sense, we might say had been laid out by others. How shall we meet these contingencies? Timidly? fearing some wise one will say: "The fool rushes in;" or shall we strike out boldly to work a successful issue? Let us remember that it is the individual, not the disease that we treat. Laws and principles that have become a part of us, in our profoundly thoughtful moments, are not to be cast aside in the face of untried or new surroundings. Therefore my defense for a movement, which some of my hearers may be pleased to call rash, is this: You are confronted by a condition leading to a rapidly fatal termination; a fact, not a theory, embarrasses you; then, if you believe that the cause of the condition, remote or direct, lies in the local disease, I hold that duty and not choice, demands immediate action.

PNEUMONIA: WHAT IS IT?

(SECOND PAPER.)

BY HIRAM CORSON, M. D.,

CONSHOHOCKEN, PA.

Though Dr. Wells has spared neither time nor labor in making a thorough history of "pneumonic fever," and, in adopting that name, sought to impress his readers with his view of its being a constitutional disease and therefore to lead them to regard the fever as the disease, and the thing to be combatted; and as the name does not indicate to the reader what the disease really is, I shall speak of pneumonia—the disease which has been so fatal during the last score of years—by the name used by those who regard it as a local affection, which, as it develops, produces an increase of heat throughout the body, with other abnormal conditions—under the name of inflammation of the lungs.

The late Professor Dr. George B. Wood, of the University of Pa., one of the most accurate describers of disease and a practitioner of the greatest eminence, says, in his *Practice of Medicine*: "Pneumonia has three stages, and is universally applied to inflammation of the spongy tissue or parenchyma of the lungs. In the first stages the blood-vessels are merely engorged with blood, and the air-cells partly filled with a sero-mucous, somewhat bloody effusion. In the second stage a plastic extravasation has taken place, and the cells are filled with

more or less concrete and bloody lymph. In the third stage the place of the plastic secretion has been supplied by a purulent fluid."

Dr. Wood was so truthful a man, had so great opportunities in the Philadelphia hospitals to see the condition of the lungs in the various stages—for they are all present at the same time where the disease continues to advance and embrace fresh portions of the lung—described by him, that I doubt not he is correct.

Dr. G. R. Martino, of Glens Falls, N. Y., in a paper read before the American Medical Association, in June, 1889, and published in its journal, September 21, 1889, remarkable for its accurate description of the disease as it exists in cases involving much of the lung, and for erroneous deductions in relation to treatment, thus speaks:

"The first abnormal symptom after the premonitory chill is the quickening of the pulse and the consequent increased flow of arterial blood. Now, if we could take a microscopic view of the minute arterial ramifications in the lung structure, we would discern a distention in the calibre of the arterial vessels in order to accommodate the augmented flow of blood; and if we would then glance at the veins, we would observe the plasma layer rapidly filling with white corpuscles, and the walls of the veins, irritated by the friction of increased circulation, would exhibit, here and there, white corpuscles adhering to their tenacious sides and finally penetrating their walls. A glance at the capillaries would show not only the white but also the red corpuscles forcing their way through the over-strained capillary walls, until the surroundings became engorged by their extravasation and the work of hepatization had commenced; for the comparatively large size of pulmonary capillaries, together with the fact of their not being supplied with vaso-motor nerves, render them easily dilatable under increased arterial pressure." Now, if we bear in mind the condition of the lungs, as described by Drs. Wood and Bartine, and which is the opinion generally accepted, we see that the disease is first a congestion, then an inflammation, and, finally, if the inflammation is not arrested, a suppuration. Dr. Wood says, that "it has been doubted whether a cure is ever effected in this last stage." If then, as I have already said, we bear these conditions in mind, we should have no great

difficulty in choosing the means to relieve the congestion of the first stage and the inflammation of the second. Measures which will not do this have but one thing to recommend them: they furnish opportunities for *post-mortem* investigations—opportunities greatly prized by the Solons of our times, as a means to prove or disprove the correctness of the diagnosis: a matter of first importance to them.

Are physicians now using means to rid the lungs of blood which is distending almost to bursting the coats of the blood-vessels and forcing the white and red corpuscles into the bronchial tubes and air-cells—as proven by the blood and the rusty-colored sputa in the bronchial tubes? Or do we let it go on, under the belief that it is a self-limited disease, and wait for a crisis, followed by a convalescence? And while waiting do we allow the suffering patient to pass from life with an illness of only two or three days, or to pass into the third stage, to a more lingering but certain death? Many persons have been lost by the belief that pneumonia is a constitutional disease, and that medicine must be given to hunt through the blood, to antidote the poison there—some, too, while the doctor waits for the crisis and the natural cure.

How do the members of our profession stand in regard to the means of cure? To me they seem to be divided into two classes, and two only: Those who try to relieve the overwhelmed and suffering lung by unloading its blood-vessels by the abstraction of blood by means of the lancet from the veins of an arm; and those who *never* bleed, but depend on giving relief by reducing increased frequency of the pulsations of the heart, with medicines which have that effect. Some give aconite, others veratria, or digitalis, or anything else that will do it: no matter to them about its depressing, poisonous action on the vital forces; no matter that digitalis, given in their large and repeated doses will cause death by a strong systolic action, or that some of the other poisonous medicines will cause death by so relaxing the heart that its feeble contractions cannot supply blood to the vital organs, and the doctor has to announce that death was caused by "heart failure": the pet name for the cause of death in pneumonia, when the patient is carried off in two or three days—a much shorter time than if the disease had taken its course without medicine being used.

When a few years ago, Bishop Vinton died in Philadelphia from pneumonia, after an illness of only two or three days, I was deeply impressed with the belief that the remedies applied for his relief might have aided the disease by their baneful action on his system. It is so difficult to so graduate the remedies spoken of above as to affect the system generally without absolute danger to life. So differently constituted are people, that doses which may be safe to one person may be dangerous to another, or useless to a third. How often since the Bishop's death have we been saddened by the loss of noble members of our profession and hosts of men prominent in the affairs of our country, by this disease, which forty years ago in this State was not dreaded by the public: so successful were physicians in curing it by the then efficient treatment. Now, the name carries terror with it everywhere. The eminent people who have died from this disease within a few years count by hundreds, and scarcely one out of fifty but died under the ministrations of the advocates of the "reformed treatment (?)," so-called by those who denounce blood-letting.

I have taken much pains to discover whether there is any one medicine used in the reformed practice, prized above all others to save life where there is a heavy congestion and rapidly advancing inflammation of almost an entire lung. "The object aimed at," says Dr. Bartine, "is to hold the pulse below eighty." Again he says: "That is not only what should be done, but what must be done to save life." Now I know full well *that is not necessary*. Scores of times, after I have bled freely with great relief to the patient and arrest of the disease, the heart, though tamed by the venesection, continued its pulsations from 80 to 100 times, or sometimes even more, for two or three days; and yet the convalescence went on. Again Dr. Bartine says: "Keep your thermometer in your pocket; it is of little or no use in pneumonia. Death does not result from high temperature, but from high arterial action. The physician who, dallying with his fine thermometer, endeavors to cure pneumonia by reduction of temperature, will make about as much headway, and will be about as successful as he would be in trying to eat soup with a peg-awl." Let me here ask Dr. Bartine, whether the increased temperature in pneumonia is not due to increased arterial action; and if so, would not the thermometer indicate to

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the physician the increase or decrease of arterial action, and thus be useful to the practitioner? Certainly just as useful in this disease as in any other. Again he says: "You may ask: with what remedies do you hold the pulse at this point" (below eighty)? and adds, "Veratrum viride seems to have served me best." Dr. H. A. Hare, who was present at the reading, said that the use of veratrum viride was an old and very useful method; but a great mistake was made in saying, "use cardiac sedatives in pneumonia," without recognizing the fact that they are to be used in the first stage, before congestion has gone on to consolidation. He said: "*The man who gives such drugs at the middle or end of an attack of pneumonia might as well stab his patient*;" and added: "Digitalis is to be used at such times." If this be true, how many patients have been sent to their graves by the use of this much used medicine. For, well do we all know, that it is the most used of all the arterial sedatives to keep down the pulse. And even Dr. Bartine has peremptorily declared it *must* be kept down; and his favorite means for that purpose is veratrum viride. But it is not only Dr. Bartine who disregards the stage of the disease, and uses it in all stages if the pulse be above eighty. I have long believed that nearly all the cases which terminated in death within four days were hurried there by this potent and dangerous drug. There are few patients with uncomplicated pneumonia who, if let alone, would die in less than a week. Dr. J. E. Atkinson, of Baltimore, followed Dr. Hare and "objected to the claim that the use of veratrum in the treatment was new; it had been many years under trial and had *not* received general acceptance." If Dr. Hare's utterance be true, then veratrum viride can rarely be used at all without killing the patient; for a physician is seldom called before the second stage has existed for some time.

I have made inquiries of many of the "no blood to spare" class, and have rarely found two that have nearly the same treatment, though they generally have in view to retard the action of the heart. Those who use aconite are afraid to use veratrum, while the latter regard aconite as not only more dangerous but also less efficient. Those who use digitalis are afraid of the two drugs just named; and those who give one or two drops every hour or two hours denounce the twenty drops given every two hours—as is

sometimes done—as being extremely dangerous. Beside these arterial sedative practitioners, there is another large class, who stand by the bedside, giving to their confiding patients sulphate of quinine in large, frequently repeated doses, to reduce the heat of the body. "If we can only keep down the temperature," they say, "we need have no fear of heart failure." Now, has not Prof. H. C. Wood, after many careful experiments, shown that, even in very large doses, quinine cannot be relied on at all to hold the temperature at a low figure? And have not Dr. Ripley, the Doctors Jacobi, and three other physicians in New York, demonstrated that it is never useful, and often greatly objectionable—really injurious—in the treatment of pneumonia? Many lives have been lost by its use; by depending on it, in lieu of better means. A friend of mine—or rather one whose friend I was—lost his life speedily by trusting to that treatment at the time when it was in good repute.

There is one other method which should be named. It is the stimulating, stuffing treatment; as much brandy or whiskey as can be crowded into the patient. Those who die under this treatment suffer horribly from the treatment. A noble young physician, in whom I felt a deep interest, a resident of Philadelphia, was hurried to the grave a few years ago under that treatment.

There are some other means used by the opponents to blood-letting, one of which I will notice. It was a favorite treatment with Prof. William Osler, of the University of Pennsylvania, a year ago. I was informed by a second-course student that Dr. Osler considered the disease to have so strong a tendency to get well, that he thought it was often better to wait and watch its progress than to resort to active measures; and that, when treatment was needed, he did little but give aromatic spirits of ammonia, fifteen drops every two hours.

So eminent is Dr. Osler that, in venturing to speak of him,

"I feel as one who dreads dissent,
And fears a doubt as wrong."

But as he is a teacher of young men, who by hundreds will go forth to practice, I may call him before you again.

Let us now reflect on what has been written by those who join hands in favor of the reformed, but fatal, practice. Dr. Bartine disregards the high temperature—"keep the

thermometer in your pocket. Keep the pulse below 80." How? "By arterial sedatives; and veratrum viride has served me best." Dr. Hare, a brother in the new practice, tells him he might as well stab his patient as to give him arterial sedatives in the second and third stages.

Another brother in the faith and practice—Dr. Atkinson—told Dr. Bartine that veratria had been employed and had not proved to be useful. Aconite and digitalis, as well as veratria, are praised by some of the brethren; while others believe them to be dangerous. Quinine and stimulants have signally failed; and yet every one of the means thus condemned by the opponents to the abstraction of blood is still used by the reformers, and Death has his own way with their patients. Nor is he less victorious over those who wait for the "tendency to recovery," without raising a hand to protect the sufferer.

I care not to speak to the readers of the REPORTER of the treatment used in other countries; but of our treatment here all should know the best mode. We are all anxious to know why so many people die of a disease which was so curable forty years ago, and which Dr. Wells says is the same disease now that it was then and has been for ages, without change of type; a disease as curable as any other inflammatory disease, but in a part of the body so important in its functions that speedy and efficient treatment is required if life is to be preserved.

I regret to occupy much of the REPORTER; but, as the editor of the *Journal of the American Medical Association* allowed Dr. Wells to occupy so much space in nine of its numbers, I beg them to let me give them one more paper.

SOME UNTOWARD EFFECTS FROM ANTIFEBRIN.

BY J. B. HATTON, M. D.,
DES MOINES, IOWA.

In the REPORTER, February 22, 1890, Dr. Brodnax, in contrasting antifebrin and antipyrin uses the following words, in reference to the dose of the former: "Any little too much has no unpleasant effect." As my experience with the drug does not correspond with his, permit me to briefly describe two cases that came under my observation:

In October, 1887, I was in attendance upon a boy sixteen years old, suffering with

typhoid fever. The temperature from the first few days of his attack ran unusually high; and, failing to control it with other means, I gave him four grains of antifebrin, left three more powders to be given four hours apart until the body heat was reduced, and went home—the case being six miles in the country. I had not been at home more than an hour when a messenger arrived in great haste, informing me that my patient was thought to be dying. I immediately returned to his bedside, and was met by the mother's question: "Doctor, what in the world did you give Willie that has acted so?" Upon inspection I don't think I ever saw a more typical case of alarming collapse than he presented. His extremities to his body were icy cold; his nose was cold; his breathing was shallow and at long intervals; his pulse was absent at the wrist; the heart-sounds were so feeble as to be scarcely perceptible; his lips, face, ears, neck, hands, arms, feet and legs were blue—indeed the skin surface presented a bewildering waste of blue; he could not speak, and his temperature in the rectum was 96.1°. With great difficulty I succeeded in forcing down his throat a tablespoonful of whiskey, containing ten grains of carbonate of ammonia, and gave him a hypodermic injection of whiskey and tincture of digitalis with other and repeated remedies against shock; and it was sixteen hours before he fully reacted. It was four days before the temperature reached its former height.

I was undecided as to the responsibility of the medicine for the effects through which he had passed, and concluded to administer it myself and stay with him to observe its action. I gave him a dose of three grains, and within an hour and forty minutes the same train of symptoms began to manifest themselves. I waited sufficient time to assure myself that the medicine would produce the same results, which it did; his lips and skin turning blue, and the extremities rapidly cooling. I did not, of course, wait for all the symptoms of collapse; but put him on restoratives and brought him out of it. I am fully convinced that the remedy caused the condition of collapse from which he had suffered.

The second case was a man, fifty-two years old, who was suffering with an aggravated attack of sciatica of the left sciatic nerve. After trying quinia, the iodides, colchicum and deep injections of chloroform, without permanent relief, I put him

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on antifebrin, four-grain doses to be given four hours apart. Within an hour after taking the second dose he was attacked with substantially the same train of symptoms from which the boy had suffered; and it was twenty-four hours before I felt safe in leaving him. While the effects were alarming in character in this case as well as in the other, the result was much more satisfactory. The antifebrin relieved his pain permanently; or, at least, for a year he was clear of it.

In these two cases there might have been, and possibly was, an idiosyncrasy; yet they show plainly that antifebrin is not altogether harmless and devoid of danger. The remarkable increase in the consumption of this class of remedies by the laity would seem to demand all the information possible as to their deleterious effects if they possess any such. This is my reason for contributing this part of my experience in connection with antifebrin.

REPORTS OF CLINICS.

BELLEVUE HOSPITAL.

SURGICAL CLINIC.—PROF. BRYANT.

General Remarks on Operation for Bone Disease.

In connection with the cases shown to the class to-day, Dr. Bryant remarked that frequently the exact diagnosis in patients suffering from bone disease is not made until an incision had permitted inspection of the diseased structures; and that it is sometimes deemed advisable, when the case is thus thoroughly understood, not to proceed to operation. A point he wished to impress was that the exploratory incision is many times followed by amelioration of the symptoms and not productive of ill consequences; so that the surgeon should never feel forced to do a radical operation when his better judgment advises against it. He referred to the boy with Pott's disease on whom he operated last week. It was decided at the time to do nothing but freshen the edges of the sinus and put in a drainage-tube. He was pleased to report that, instead of a daily temperature of 103° and more, his fever had gradually decreased, never rising above 102° , and his temperature when last taken was 100° . His pulse showed a corresponding improvement. Altogether

the little patient was much better; and yet no diseased bone had been removed. To be sure the parts had been rendered more or less aseptic and the drainage free.

Necrosis of Humerus.

The first patient brought in for operation was a lad, ten years' old, with the following history. On May 1, while roller-skating, he fell upon his right side. The upper part of the arm grew swollen and painful. Fever set in. The swelling increased for several days until finally the overlying tissues thinned and pus was evacuated, leaving a sinus that continued to discharge. Last August an incision was made and a sequestrum was removed. The sinus did not heal, however, and has continued to discharge. Examination showed considerable wasting of the right arm, and on the external surface, an inch and a half below the situation of the head of the humerus, there was a depressed scar, in which was the mouth of the sinus with pouting lips. The probe showed the direction of the fistulous tract to be upward, reaching to the level of the border of the cartilage. An incision was made down upon the sinus, the periosteum was pushed aside, and the diseased bone was scraped out, carefully and gently, so as not to injure the joint. It was found necessary to scoop out nearly the entire head of the humerus. Frequent irrigation was practiced.

Dr. Bryant said the wound might now be dressed in one of two ways. The first was by allowing the cavity in the bone to fill with blood and simply covering the surface with iodoform gauze and air-tight dressing in the expectation that the blood would become organized and the wound heal with but little suppuration. The danger here would be that some diseased focus in the bone might escape the operator, or that some fistulous track in the bone might retain some of the elements of inflammation, so that, however thoroughly the cavity might be washed out and disinfected these points would not permit of perfect asepsis. The second way was to allow the wound to heal from the bottom by granulation. In this case he considered the chances of getting perfect disinfection so small, and the oozing of blood was of such considerable quantity, that the first method was impracticable. Accordingly the wound was dusted with iodoform, packed with iodoform gauze; and healing by granulation was looked for.

Should the patient to-morrow or later develop fever or evidences of inflammation, it would lead to a suspicion of involvement of the joint. In that case the dressings should be removed and the wound inspected, and, if necessary, the joint opened.

This case may have been originally either a periostitis of the shaft, with the pus burrowing up into the head of the humerus, or (as he was inclined to view it) an abscess of the head of the bone. In these latter cases, as a rule, the disease advances into the joint. This patient presented an illustration of the exception. From whatever cause, the condition resulting, and its treatment, are the same. The operator should avoid injury to the cartilage or articulae lamellae; use no violence and scrape lightly; and use water (irrigate) freely.

Necrosis of Metacarpal Bone.

The next patient presented for operation was a man, a fireman by occupation, thirty-two years old. He gave a good family history, and had never been sick before. He had no history of syphilis. His present trouble dated from four weeks ago and then, while he was hoisting a can of ashes, the chain broke, and the can fell and struck him on the right shoulder and hand. Following this the dorsum of the hand swelled and grew painful, and after a few days was incised by the physician in attendance and gave issue to pus.

Examination by Dr. Bryant showed the depression of the scar of the incision, and a sinus located over the head of the third metacarpal bone. The probe discovered bare bone.

Dr. Bryant directed attention to four points that should interest the surgeon when using the probe in these cases: first, to determine whether dead bone was present or not; second, if so, to ascertain the extent of the necrosis; third, to find whether the sequestrum be loose, or firmly attached; and, fourth, to learn whether or not the joint was involved.

An incision was made through the sinus down upon the metacarpal bone, and the bone was exposed and found to be soft. The soft material was scraped away until a bleeding surface presented. As some small pieces of cartilage were washed away when the wound was irrigated, it was presumed the joint was involved.

The cavity was plugged with iodoform gauze, and the further antiseptic dressing

applied, care being taken in applying the bandage to keep the fingers straight—a precaution that should always be employed. Otherwise a crammed and crooked condition of the fingers might result, impairing the usefulness of the hand.

FOREIGN CORRESPONDENCE.

LETTER FROM PARIS.

PARIS, February 7, 1890.

Pneumonia in Influenza.—*Bacteriological Researches and Clinical Forms of Influenza.*—*On the Anti-bacterial Action of White of Egg.*—*Extirpation of an Occipital Encephalocele.*—*Treatment of Sprains.*—*Contagion of Dysentery.*

At a recent meeting of the Medical Society of Paris, a very interesting discussion took place on the subject of "Pneumonia in Influenza." Dr. Duponchel thinks this affection to be of an entirely different nature from the ordinary pneumonias observed; it is preceded, according to this physician, by a premonitory state, lasting from eight to ten days; it is not ushered in by a chill; the sputa are not rusty; finally, this form of pneumonia, instead of running a fixed course, presents recurrences and finally ends with a profuse sweat and general weakness—the capsulated diplococcus has never been found in the sputa of his patients with the pneumonia of influenza.

Dr. Laveran has observed cases similar to those of Dr. Duponchel, but he has also met with real infectious cases of the disease. In five patients he observed the co-existence of purulent pneumonia and pleurisy; in another, a purulent peritonitis and pleurisy were observed, and in this patient the spleen was enormous and weighed 525 grammes (about 16 ounces). This author has never found streptococci in the blood of his patients, but he has found them in the sputa.

Drs. Chantemesse and Widal, the two well-known bacteriologists, have examined the blood of eight of their patients, during the period which followed a high temperature of 39° to 40°. The blood was obtained from the pulp of a very clean finger, and placed between glass-plates; this blood contained a great number of polynuclear leucocytes, but never have they found a para-

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site, and culture plates even gave entirely negative results. These authors have observed, however, in certain cases, a peculiar fetid odor of the expectoration in cases in which influenza was complicated with bronchitis.

Drs. Vaillard and Vincent claim to have arrived at constant results, during the present epidemic of influenza, in their bacteriological researches. They have examined the viscera, the blood, the liquids of the serous cavities, as a result of the evolution of broncho-pneumonia due to influenza.

They claim to have always encountered, both before and after death, the presence of one same organism, a streptococcus. This organism, in a morphological point of view, as well as by his modes of culture, has appeared identical with the one of erysipelas. In subjects who have died from influenza, one finds a streptococcus in the blood, spleen, lung or exudated liquids. Three times out of four, this microbe was absolutely alone; in one case the spleen contained the staphylococcus pyogenes. In empyema, consecutive to influenza, one finds only one kind of streptococcus. The same streptococcus is constant in sputa obtained from subjects suffering from influenza.

Dr. Netter thinks one ought not to form hasty conclusions; for this streptococcus is often found in the normal saliva; hence it is not surprising if it is met with in the sputum. This streptococcus is also not the only cause of influenza; for Dr. Netter has seen two pneumonias which presented pneumococci; and three cases of otitis: in one with streptococci, two with pneumococci.

Dr. Henri Huchard also gave a description of some of the clinical forms of influenza. Passing rapidly over the usual, yet most dangerous complications of this disease: bronchitis, broncho-pneumonia, catarrhal pneumonia, he said that there exist two principal forms of pulmonary congestion, the active form of congestion and the passive form of the disease. This last form, the passive or atelectitic form of the disease, continues for several weeks. It is more often bilateral, and situated at the base of the lung; the physical signs are fine crepitant râles, very numerous, especially on deep inspiration. Much more severe complications may arise if the patient exposes himself to cold. This congestive state is due to a pulmonary weakness, a lessening of bronchial contractility and loss of elasticity of the pulmonary vesicles. In certain cases of

pneumonia we find symptoms, as if the pneumogastric nerve had been cut. Cardiac influenza presents itself with fainting, syncope, slowing of the pulse, intermittent character of the same, even forms resembling angina pectoris and cardiac collapse. An interesting symptom has been observed by Huchard: when the patient changes his position from the horizontal posture to the vertical, the pulse becomes accelerated and will rise from 80 to 120, or even 130, beats per minute. As soon as the patient lies down again, the normal ratio is resumed. This is a certain sign of cardiac debility and weakness of the arterial pressure. From a therapeutic point of view this indicates that the heart is to be strengthened with appropriate remedies, and the much enfeebled arterial pressure is to be increased.

These cardiac troubles may be due to two different causes: either to an influenza myocarditis, or to disturbance of the cardiac innervation. Dr. Huchard does not deny the existence of myocarditis; as influenza presents itself in certain cases as an infectious disease; but that accidents are observed, indicating a parietic state of the pneumogastric, as shown by the pulmonary congestion and slowness of the pulse.

Finally Dr. Huchard mentioned gastro-intestinal influenza, which in some cases is of an infectious character. In such cases, the tongue remains for several weeks and months covered with a thick coating, there is complete loss of appetite, the liver and spleen become very large, the urine is scanty and sometimes contains albumin, the feces are very fetid, and the patient feels very weak. In such an infectious state, the heart must be strongly supported; and the normal excretory organs must be kept active to prevent secondary poisoning. In such cases, convalescence is very much protracted and an examination of the urine shows a great diminution of the phosphates and phosphoric acid.

Before the Biological Society, Dr. R. Wurtz read a very interesting article on the "Anti-bacterial Action of White of Egg." To demonstrate this interesting fact, very small quantities of pure cultures of different micro-organisms were placed in white of egg; these tubes were then placed in a culture oven at a temperature of 38° Cent., and kept there a certain definite number of hours; to each tube is then added ten times the volume of nutritive gelatine, and with this mixture plates are prepared. At the

same time a control plate is prepared from a tube of nutritive gelatine, on which the same quantity of culture has been placed, and on which one counts the number of colonies which have developed. Dr. Wurtz has experimented on the bacillus anthraxis, the cholera spirillæ, Eberth bacillus, the pyocymic bacillus, the microbe of chicken cholera, the staphylococcus pyogene aureus and the bacillus rubtilis. The bacillus anthraxis, either in filament or bacillary form or in spores, is destroyed in one hour, in white of egg at 28° C. On the other microbes above named, the action, if not so pronounced, is almost as clear. The number of colonies diminish hourly, according to the length of time during which the micro-organisms remain in contact with the albumin. At the end of six hours there are very few colonies on the plaques prepared with albumin, while the control plate is covered with micro-organisms. It will be interesting to note, that in this liquid there are no foreign bodies, such as remains from leucocytes and red blood corpuscles; the white of egg is a perfectly amorphous liquid, containing no foreign element; hence, to explain its actions on bacteria, the intervention of histological elements or the phagocyte action are to be entirely discarded; its action belongs to physico-chemical activities.

This property of resistance of the white of egg to bacterial action, probably plays a certain rôle in the preservation of the bird's egg and perhaps, also, of the batrachian and certain fish-egg.

Dr. Paul Reclus recommends the following treatment against sprains, and has found it very successful both in his hospital and private practice. As soon as a patient comes, suffering from a sprain, and his local condition has been recognized, he is ordered a very hot local bath, as hot as he can bear it, to be continued for ten to fifteen minutes; then massage is to be resorted to for the same length of time; finally an elastic bandage is to be applied, beginning at the extreme part of the toes. The bandage must not be applied too tight; just tight enough to hold in position. The massage must be done in one direction only, all the movements must tend to break up the clots that might have formed, and to diffuse the exudated liquid as much as possible towards the cellular tissue of the lower part of the leg. This must be done all over, twice a day, every twelve hours, morning and evening; and the author claims that in ten days

most of the sprains can be cured, and the patient able to walk about.

Dr. G. Lemoine, of the Military School of Lyons, has written an interesting work on the contagion of dysentery. His conclusions are that dysentery is propagated by the rectal evacuations, directly or indirectly, by impregnating the air, food and water used by man. The direct transmission of dysentery takes place through the medium of water-closets or any vessel that has previously received specific dejections, particles of which, having remained adherent to the vessel, come in contact with the lower extremity of the rectum and anal region of man.

PERISCOPE.

A Test for Albumin in Urine.

In the *Johns Hopkins Hospital Bulletin*, Feb., 1890, D. Meredith Reese calls attention to an editorial note in the *British Medical Journal*, Nov. 16, 1889, in which a new test for albumin in urine was given. Trichloroacetic acid CCl_3COOH , a substitution product of acetic acid, formed from acetic acid by the replacement of three of its hydrogen atoms by three chlorine atoms occurs as a crystalline salt, and is colorless and readily soluble in water. Boymond claims to have been the first to make mention of the reagent, and since this it has been adopted by Raabe. Boymond begins his article by saying that Marsalt and Languipin have described albuminous urine in which a precipitate by heat was gotten, but in which urine the precipitate was re-dissolved by acetic acid. Patein, in a note quite recently made, attributes this fact to the presence of a special albumin differing from serum albumin and globulin. Boymond has observed this phenomena repeatedly, and considers that the condition is much less rare than supposed, and that the peculiarity has much import; for in a rapid examination of urine where heat and acetic acid are used alone, we might perhaps conclude that albumin was absent, when the urine might contain considerable proportion of this special variety of albumin. He has been accustomed for some time to employ trichloroacetic acid instead of acetic acid. Other agents which precipitate albumin also precipitate this variety, but trichloroacetic acid presents some advantages, and particularly that of

not changing the albumin. The reagent precipitates albumin in cold solution, and is considered to rank among the most delicate tests. Raabe, in the article referred to above, considers it extremely sensitive, superior to HNO_3 and to metaphosphoric acid, advocated by Hindenlang. Raabe gives the relative amounts of albumin recognized by metaphosphoric acid, nitric acid and trichloracetic acid as in the proportion 1: 3.7: 6.2. He also states that .0295 grm. of albumin can be recognized in 250 cc. of urine.

It may be employed as a solid or a liquid. When used as a solid a crystal of the salt is dropped into the urine in a test-tube, and touching the bottom is dissolved, producing a diffuse turbidity or turbid zone definitely marked out. When used in liquid form, the solution may be saturated or of medium strength. The saturated solution is used after the method employed with HNO_3 in Heller's test, by floating the urine on the acid. A characteristic ring will be formed, as one finds with the HNO_3 test, but without the production of the colored zone between the urine and acid caused by the oxidation of the pigments. When urine is rich in urates of soda error will be avoided, an error common to all reagents, by diluting the urine with the addition of distilled water. Boymond closes his paper by saying that he confirms the observations of Marsalt and Languipin, and that he wishes to draw attention again to trichloracetic acid as a useful test in not only this particular variety of albumin, but in the ordinary forms.

In the last few months this reagent has been tried in the clinical laboratory of the Johns Hopkins Hospital. The article was obtained from Merck and found to be, as Boymond describes, a crystalline salt, colorless and deliquescent. In all the tests a saturated solution was used, making a liquid of the consistency of HNO_3 . This was kept well stoppered to keep it of uniform strength in the experiments. It was employed as above described by pouring the acid beneath the urine by means of a pipette.

In all, eighty-seven different urines have been tested, the urine filtered, and that from women drawn by catheter. At first only these urines, showing albumin by control tests such as heat, HNO_3 and picric acid, were used, and in all cases trichloracetic acid gave a distinct, clearly defined zone, produced immediately, with no discolora-

tion whatever between the urine and acid. Generally the zone was produced more quickly than with nitric acid and was of a greater thickness and intensity. On standing for some time a slight pinkish discoloration may in some cases be obtained below the urine in the acid when trichloracetic acid is used.

In forty-three cases where the control tests gave albumin a precipitate was obtained by trichloracetic acid, not dissolved, but made more distinct by heat. In twenty-five cases no reaction whatever was obtained by any test. In fourteen cases where there was no reaction by control tests, the trichloracetic acid gave a precipitate. In eleven of these cases granular, epithelial and hyaline casts were found, and in three of these eleven cases the *post-mortem* showed distinct changes in the kidneys. In three cases where heat and acetic acid and nitric acid gave no precipitate of albumin, a precipitate was obtained by picric and trichloracetic acids. In all three of these cases casts were found. In two cases where the precipitate on heat was dissolved again by acetic acid, trichloracetic acid gave a good precipitate. In conclusion it may be said that trichloracetic acid has proven a most delicate test for albumin in urine; that it is prompt in its reaction; that it gives no discoloration or colored zone; that it is a test easily applied and one worthy of more extended use.

Influence of Cold in Pneumonic Infection.

Dr. G. Lipari, of Palermo, in his recent experiments on the infectious nature of fibrinous pneumonia, essentially confirms what is known of Fraenkel's pneumonococcus, and has also succeeded in proving the influence of cold as a factor in the origin of fibrinous pneumonia. The endo-tracheal injection of pneumonic sputa or pleuritic exudation of animals which had died from pneumonococci gave a negative result, but when the author, before or after the endo-tracheal injection, exposed the animals to cold, the result was very different. Of eight animals so treated six died with clearly established pneumonic infiltration. The author supposes that the cold paralyzes the ciliated epithelium of the bronchi, and at the same time causes their mucous membrane to swell, both of which pathological processes

favor the descent of the infectious material into the alveoli. These experiments were doubtless undertaken with a view to harmonize the old and new teaching upon the origin of this prevalent disease.—*Lancet*, February 22, 1890.

Treatment of Keloid.

Dr. George T. Welch, of Passaic, N. J., reports, in the *New York Medical Record*, Feb. 15, 1890, an interesting case of keloid treated by painting with collodion and iodine, and resulting in cure.

Keloid, he says, is seldom, if ever, regarded as curable, most authors relegating it to the limbo of opprobrium medicinæ at once, though Dumreicher is said to have succeeded in removing one from the lip by the application of acetate of lead and alum in the form of an ointment. Its proneness to recur after excision is the more remarkable, as it is regarded as a hypertrophic growth of the fibrous tissue of the surface, and seated in the corium itself—a part easily accessible, and to be removed without difficulty. But after the excision of a true keloid it would seem that the traumatic variety is developed in the cicatrix, a tendency to the disease being now hereditary in the surrounding cellular tissue. Even in such cases Dr. Welch is inclined to believe that persistent applications of collodion and iodine under proper methods, if persevered in for several months, might effect a cure.

In the spring of 1888, J. B., a thriving Swede, interested in oyster-planting in Raritan Bay, consulted Dr. Welch in reference to a keloid on the back of one of his hands, which he had recently injured while assisting a workman in dredging. The keloid was angry in appearance, and very painful. The patient was anxious to have it removed, but, being a sensible man, after hearing the result of the use of the knife, he agreed to continue, for an indefinite time, such remedies as I might prescribe.

After multiple linear scarification, as advised by Vidal, from which plentifully exuded big drops of black-looking blood, the surface was dried and then painted with collodion. The collodion was now continued for fourteen days, when it was allowed to scale off. The keloid was somewhat contracted and depressed, but a fantastic crop of coral granulations sprang up in all directions, and, as it were, in a night, some of

them interlacing, and all attended with an intolerable itching. Scarification was again practiced, but the collodion was enforced with tincture of iodine:

R Tr. iodinii f3ij
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M.

This was applied freely, and the parts were painted over daily for a fortnight, when the continued cracking of this varnish would cause slight bleeding, and it was then permitted to scale off. Scarification would again be performed, the collodion and iodine reapplied, and the above process continued as before. Many times the cicatricial granulations would reappear, and sometimes the keloid would spread out sideways in a new direction, but, upon the whole, an encouraging progress was at length manifested. The centre of the affected part became mobile, and of a natural color, and finally the margin was cured in spots, and the dimensions of the whole decreased from a diameter of three inches to a semi-lunar elevation next the fingers of two inches in length. The treatment, without variation, for this went on until, after about eighteen months from the beginning of the process, the disease had entirely disappeared, and the skin, slightly purplish in appearance, was flexible and healthy, and this without internal medication.

Hypnotism and Clairvoyance.

Professor William James, of Harvard, in his article on hypnotism, in the current number of *Scribner's Monthly*, says: "I know a non-hysterical woman who, in her trances, knows facts which altogether transcend her possible normal consciousness, facts about the lives of people whom she never saw or heard of before. I am well aware of all the liabilities to which this statement exposes me, and I make it deliberately, having practically no doubt whatever of its truth. My own impression is that the trance condition is an immensely complex and fluctuating thing, into the understanding of which we have hardly begun to penetrate, and concerning which any very sweeping generalization is sure to be premature. A comparative study of trances and subconscious states is meanwhile of the most urgent importance for the comprehension of our nature."

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The Editor will be glad to get medical news, but it is important that brevity and actual interest shall characterize communications intended for publication.

TREATMENT OF TYPHOID FEVER WITH COLD BATHS.

There have been several discussions recently in the medical societies of New York on the treatment of typhoid fever; and at a recent meeting of the Section on Practice of the Academy of Medicine, Dr. Simon Baruch read a paper on this subject, which was intended as a sort of review of these discussions, and which contained an earnest appeal for the general adoption of the cold-bath treatment used and recommended by Brand. That there is urgent need for some change from the methods most in use Dr. Baruch thinks will be clear when we reflect that the death-rate from typhoid fever in American cities is still from twenty-five to forty per cent., according to the latest reports. This contrasts very unfavorably with the figures which the Brand method gives in

Germany. The marvelous success of Brand, who lost only one out of three hundred and forty-two cases, was due, he said, to the strictest attention to detail and the subjection of every case that showed the slightest suspicion of typhoid symptoms to the bath treatment. Dr. Baruch believes that a mild bath treatment is advantageous in any febrile attack in which the temperature reaches 103° , and that, if it proves to be typhoid, valuable time will have been gained. The notion of the fatal influence of high temperature, he says, is happily losing its hold on the profession, and he regards it as very unfortunate that the cold bath should have been classed—under the teachings of Liebermeister and others—among antipyretic measures. Whenever the profession gives up this fallacious idea, he thinks that the cold-bath treatment will replace the unsuccessful antipyretic treatment entirely.

Thus in the Fourth Congress for Internal Medicine (in 1885) eminent clinicians expressed almost unanimously the opinion, that, until we obtain a specific curative agent for typhoid fever such therapeutics is to be preferred which is capable of diminishing or removing the effects of the morbid agents; that this aim is most surely fulfilled by hydrotherapy; and that medicinal antipyretics act only against temperature elevation, but do not, like the bath, produce a modifying effect upon the fever process.

Dr. Baruch criticised the speakers in the recent discussion who advocated intestinal antiseptics in typhoid, and said that in the light of the experiments of Stieff, in Gerhardt's clinic, the attempt to free the intestinal canal from putrefactive agents seemed to be Quixotic. Putrefaction is due to the presence of decomposing tissue elements and secretions from intestinal ulcerations; and if we could prevent or limit the latter we would remove the cause. It can no longer be doubted that this may be done if we credit Vogt's testimony to the great diminution of diarrhoea and meteorism by the bath treatment. The cold bath, which reduces

the temperature, strengthens the heart, deepens the respiration, improves the digestion, increases diuresis and perspiration, and which brightens and refreshes the patient, must prevent the tendency to accumulation of effete materials in the system. Another point brought out by one of the speakers was the value of solid food in the third week of typhoid, and Dr. Baruch thought it was not simply a coincidence that the advocate of feeding (Dr. Peabody) was also the only advocate of systematic bathing who appeared in the discussion. Tripier and Bouveret, he said, dwelt upon the remarkable appetite and digestive power of patients who were systematically bathed; and Dr. Austin Flint, who introduced systematic bathing into his wards at Bellevue Hospital last spring, had told him that the appetite of his patients was difficult to appease.

Dr. Baruch then went on to say: The most important question in the recent discussion is, "What constitutes the cold bath treatment?" The statistics referred to, showing a reduction of mortality to less than three per cent., and in twelve hundred cases treated before the fifth day, to less than one per cent., were not obtained by cold sponging, wet packs, cold coils, cold effusions, graduated baths, or any other agreeable substitute; they were the result of methodical bathing, according to Brand's original method.

As there seems to be much vagueness of conception on this point, Dr. Baruch deemed it important to furnish an outline of the method, as he had learned it from the study of Brand, Vogt, Tripier, and Bouveret, and correspondence with Brand himself.

1. The first principle is to bathe early; even before the diagnosis is clear. No harm is done, at least by a graduated bath, viz., reduced from 90° to 68°, for a quarter of an hour. This is the only modification of the method which is advisable. It accustoms the patient to the treatment and gains time. It should be resorted to as soon as the temperature *in recto* reaches 103°. Dr. Baruch bathes the

patient's face and chest with ice-water before placing him into any bath.

2. As soon as the case becomes defined or even suspicious, the strict bath—65° F.—should be used. The tub must stand at the patient's bedside filled two-thirds with water at 65°. The patient receives a stimulant, and has his face and chest washed with ice-water. He is undressed and gently lifted into the water. A gasp and a shudder follow—perhaps an ejaculation of distress. But gentle reassurance, by word and deed, a calm demeanor devoid of haste or flurry, and an avoidance of force will do much to quiet the patient. With one hand under his head, if necessary, the other is used to gently practice friction on the submerged parts. A second nurse pursues the same course, if possible. This important feature of the Brand method is frequently neglected, and to its neglect may be charged the recurrence of collapse, cyanosis and chill. Gentle friction with the outstretched hand produces a rosy hue of the skin and the superficial vessels are dilated. By thus exposing a larger supply of blood, the cooling is more rapid. The bath should continue in this manner for fifteen minutes, no matter how urgently the patient desires to be removed. A pinched countenance, chattering of the teeth, unless excessive, or a small pulse, must not be taken as indications for removal; but if the face becomes cyanotic or the respiration embarrassed, the bath must cease. Every five minutes during the bath, water at about 60° should be gently poured from a pitcher on the head of the patient, after a folded handkerchief has been tied around it like a bandage, with the knot over the nucha. This prevents the water from running over the face and spreads it over the head. Before the patient is removed from the bath a linen sheet should be spread on a blanket to receive him. If his temperature has been high, this sheet alone is wrapped around him, while his lower extremities are covered with the blanket also. If his temperature has not been over 103.5° the whole body may

be wrapped in the blanket over the sheet, and hot bottles placed to the feet. He is then left to dry for ten or fifteen minutes; something hot is now given him; his nightgown is replaced, and his temperature is taken. This process is repeated every three hours, so long as the temperature reaches 103° , night and day, unless the patient is asleep naturally. Stupor, coma or delirium are all indications for the bath, even if the temperature is below 103° . In these cases placing the body semi-recumbent with a half-bath at 95° , and pouring small basins of water at 60° to 65° over the head and shoulders is a more valuable procedure than the complete bath.

The Brand bath is not a nervous sedative, as has been claimed in a recent paper before the State Society, but a refreshing measure, by which the depressing effect of the typhoid poison is to be counteracted. The system is tottering under the enfeeblement of all its functions from the effects of the infection upon the nervous system. The impact of cold water upon the periphery deepens inspiration, more oxygen is inhaled, more carbonic oxide is given off; the refreshing impulse is conveyed to the nerve centres from which the heart and stomach receive tone and the secretions activity.

From this description it can readily be seen that, however beneficial the Brand method may be in its effects, it is most exacting in its requirements; and unless these can be fully met it would seem to be better not to attempt to practice it at all. Few of our best appointed hospitals have a sufficient corps of nurses to care for many typhoid patients in accordance with the demands of this treatment, and but few private families can afford the expense of, or have accommodations for, four nurses—the number which is required for the day and night service. More than this, it will probably be noted that the excellent showing of results claimed for Brand's method may in part depend upon the fact that, as it is taught that it must be instituted before the diagnosis is certain, it is quite

possible that the statistics include cases which were not of typhoid fever at all and which would, of course, improve the showing for recovery.

With these reserves, we present to the readers of the REPORTER the views of Brand, so warmly and so ably advocated by Dr. Baruch.

INVITATION FOR PHYSICIANS TO ADVERTISE.

The *Arena*, of Boston, may be an admirable magazine, and if on better acquaintance we should find it so we would be pleased to announce the fact to the readers of the REPORTER. But the *Arena* does not commend itself especially to our favor when it sends to the Editor of the REPORTER a circular, intimating that he is regarded as one of the "leading physicians" in the United States, and inviting him to pay a modest sum of money for having his name printed as such in the *Arena*.

The invitation is baited with the statement that the publication of the names of "leading physicians" is intended for the benefit of the readers of the *Arena*, and an intimation that this is a mode of advertising "without breaking the code that hedges in the medical profession" which would be both cheap and effective. How hard it is to resist the temptation to buy a place in this galaxy may be judged by the thousands who have doubtless received an invitation to enter it, each one of whom is assured that the publishers "want none but the cream of the profession and only one from each point indicated."

The *Arena* may be, as its publishers claim, the "leader in the field of impartial discussion of all the questions, great and small, that present themselves before the public gaze." It certainly has reason for recognizing its ability to take up a very small one. But we doubt if many medical men will follow it, and feel sure that those who do will not be men of very large personal or professional caliber.

As for the poor readers of the *Arena*, we trust they will find out how the publishers have attempted to skim the "cream" off of the profession for them and judge for themselves what quality can be expected from such a process.

THE STATUS OF MEDICAL EXPERTS.

One of the greatest obstacles to securing for physicians, who testify as experts in Court, the consideration which experts should receive, is the fact that their testimony is sometimes calculated to diminish rather than to increase the confidence and respect of those before whom they testify. It is notorious that absolutely contradictory expert testimony is sometimes given in a single case, and that the history of the Courts furnishes too often the spectacle of so-called experts whom it seems safe to employ in the defence of almost any murderer; while, on the other hand, there are to be found men who seem too ready to give positive opinions on scientific points by no means clearly established, when the fate of a fellow-being hangs upon their words.

In like manner medical men are sometimes found, speaking as scientific men before deliberative or administrative bodies, who appreciate so imperfectly their responsibilities that they make assertions, the correction of which, while injuring their own reputation for reliability, has also the effect of shaking the confidence of those who listen in expert testimony in general.

Not long ago, in Philadelphia, a rich corporation, with designs on the city's treasury, secured the services of a widely known chemist, to demonstrate that the Schuylkill River furnished to the inhabitants of this city water unfit to drink and dangerous to health. It was soon shown, however, that the published analyses of this very chemist demonstrated the very opposite of what he had said, and that there was no evidence accessible to support his sweeping assertions; and not only this chemist, but chemists in general, fell in the estimation of the

community. Very recently a certain microscopist of this city appeared before a Committee of Councils of Philadelphia, and made a long address on the same theme, dwelling especially upon the assertion that Philadelphia has more typhoid fever than any other large city in the United States, and intimating that this was due to the use of Schuylkill water. On being questioned in regard to the parts of the city in which the typhoid most prevailed, he said that this had been fully discussed in the medical societies of which he was a member, and that it was always found that typhoid fever was excessive "where the water was worst." This evasive statement seemed plainly intended to convey the idea that typhoid fever was especially prevalent where the Schuylkill water—which he had been arguing against—was used; and it became necessary for another medical man, who was present, and who was a member of the same medical societies, to state that at these societies it had been demonstrated that typhoid fever was most frequent in Philadelphia precisely where the water of the Schuylkill was *not* used!

Here was a case in which the listeners might have supposed that the first speaker was either ill-informed or not quite candid; and—even if this inference were erroneous—the effect on their minds could hardly fail to lead them to accord less respectful attention hereafter to medical men who appear before them in the capacity of experts.

We share the desire of our brethren in the medical profession that they should be treated with due consideration when they speak on subjects about which they ought to know more than their hearers; but we feel sure that the best way to secure such treatment is to do what they can to avoid themselves, and to discountenance in others, actions and words which are open to the objection that they indicate ignorance or insincerity on the part of so-called experts. Men who err in this do themselves harm which is, perhaps, their own affair; but

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they also injure the profession—which is its affair.

ARTESIAN WATER AT MEMPHIS.

The *Bulletin* of the Tennessee State Board of Health, February 20, 1890, contains a very interesting account of the system of water-supply at Memphis, which is now as fine as any city could have. This account would interest any one who cares to know the principles and methods of artesian water-supply, and would prove instructive to any who are not familiar with the subject.

So far as Memphis is concerned, it is gratifying to learn that the supply of artesian water at Memphis is practically inexhaustible. Such is the capacity of the water-bearing sand, and so enormous its area for gathering its store, that it is thought that Memphis, in using profusely all she may need for years to come, cannot make an impression on the sea of supply below. It is assured that there is no possibility of an admixture of the river or surface waters about Memphis, or of sewage fluids, with the waters of the artesian wells. The upward pressure from the wells, to a point even above high water of the Mississippi, gives this assurance.

The quality of the water for all city purposes has proved highly satisfactory. Its source is from a region boasting of its water, and from that it percolates through miles of sand, coming out transparent and sparkling, unaffected by washing rains or turbid streams. Its introduction was an epoch and a blessing to all concerned. Finally, the system for gathering and controlling the self-flowing water, and for sending it through the iron arteries of the city, is not only unique, but admirable in conception and execution.

While congratulating the inhabitants of Memphis upon securing so magnificent a supply of water for drinking and domestic use, it is pleasant to know that artesian well-water is within easy reach of many other cities in our country, especially in the great Valley of the Mississippi.

BOOK REVIEWS.

[Any book reviewed in these columns may be obtained upon receipt of price, from the office of the REPORTER.]

PROCEEDINGS OF THE PHILADELPHIA COUNTY MEDICAL SOCIETY. Volume X. Session of 1889. 8vo, pp. xvii, 410.

This volume contains the papers read before the Philadelphia County Medical Society between January 9 and October 23, 1889. Sixty-eight papers were read, and while there is of necessity great difference in their relative merit, they are all creditable to the Society. The discussions, as usual, have been earnest, and they add much to the value of the proceedings. Among a number of papers deserving special mention is Dr. Guss's paper on the The Mortuary Statistics of Philadelphia; Dr. Keen's papers on Tapping and Irrigation of the Lateral Ventricles; Robert Abbe's on Intestinal Anastomosis; and Frederick P. Henry's on The Diagnosis and Treatment of Functional Disorders of the Stomach, which should be read in connection with the paper of Dr. Wolff, on The Chemistry of Gastric Digestion. The book is well printed and bound, and presents a handsome appearance altogether.

A COMPEND OF HUMAN PHYSIOLOGY. Especially adapted for the use of Medical Students. BY ALBERT F. BRUBAKER, A. M., M. D., Demonstrator of Physiology in the Jefferson Medical College, etc. Fifth Edition, Revised and Enlarged. With new Illustrations and a Table of Physiological Constants. 8vo, pp. 188. Philadelphia: P. Blakiston, Son & Co. 1889. Price, \$1.00.

It is scarcely necessary to review at length Dr. Brubaker's well-known compend. It has been in use by students for some years, and the fact that it has already reached a fifth edition indicates the esteem in which it is held. In the present edition the author has revised and rewritten a number of sections, but the principal additions are in the parts treating of the nervous system. The subject-matter of the book is well divided and subdivided, and the arrangement throughout is good. The only criticism at all unfavorable, which might be made, as regards the appearance of the book, is that the combination of ink and paper is trying to the eye-sight. But we should not expect everything in a compend.

RAMBLES OF A PHYSICIAN; OR, A MID-SUMMER DREAM. By a Graduate of the University of Pennsylvania. 2 vols. 8vo. Illustrated. Philadelphia: Dunlap & Clarke, Printers.

The author of this book employed the opportunities of a tour in Europe to write an account of his travels, which is full of interesting experiences and observations. He had an eye for all that was beautiful, and another to mark many a defect in European cities. He seems to have had a peculiar sympathy for the charms of German life and German idealism, and gives many a quotation from the poets and other writers of this land. He did not miss his chance to fight a duel in Berlin; where—as an American should—he got the better of his German antagonist. His book contains many allusions to matters of historical interest, and impressions made by the various works of art that he saw; and gives a faithful representation of the feelings natural to one traveling, as he did, in a rambling way over the most interesting parts of Europe,

LITERARY NOTES.

—The first number of the *Literary Digest* was issued March 1, 1890, and is an interesting and instructive number. It gives promise of carrying out very well the purpose indicated in the prospectus of presenting carefully prepared condensations of important articles in the periodical literature of the world, with comments on current events, book digests and criticisms, indices of current literature and a chronicle of public events.

The *Digest* is to be issued weekly, by Funk & Wagnalls, New York, and the subscription price is \$3.00 a year.

NEW REMEDIES AND APPLIANCES

In this department, notice will be given of Remedies, Food Articles, and Instruments or Surgical Appliances of which specimens are sent to the Editor; it will bear the same relation to these articles that the department of Book Reviews now does to books.

Clam-Juice Food.

E. S. Burnham, of New York, sends a specimen of "Clam Bouillon," which is recommended as a useful article of food for patients with weak stomachs. It is certainly palatable and ought to be nutritious. It has one very distinct merit, namely, that it does not have the character of "sick-room victuals," and can be used with satisfaction in the kitchen for well people.

CORRESPONDENCE.

Insanity and Obstruction of Bowels.

TO THE EDITOR.

Sir: In the *Periscope* of the *REPORTER* for March 1, is an article on Insanity proceeding from the Colon. Allow me to contribute my moiety to further what is there recorded. Some eight years ago I was called to examine a man, in order to give a certificate of insanity. During the examination (and after I was convinced that he was undoubtedly insane) it occurred to me to inquire after the condition of his bowels. They had not been moved for over a week, so I persuaded him to try an immense dose of calomel followed by aloes and podophyllin pills. Not expecting any special effect upon the mental condition, I returned home, and prepared certificate of insanity. But the man never needed it. On the following day, a vast amount of material was discharged from his bowels and his mind cleared up, and he has remained sane ever since.

A young woman has been under my care three different times for insanity. The last attack was about two years ago. She had been constipated for quite a long time, was an enormous eater and had gained flesh rapidly. Finally, her mind failed. Her bowels were completely moved by means of injections and cathartics, and her friends stated that some of the material passed had been eaten over six weeks before. On all three of her attacks a free evacuation of the colon was followed by immediate improvement of her mind; although her general system remained affected for quite awhile afterwards. She now watches the condition of her bowels, cuts down her food and is perfectly well.

Yours truly,

JAMES BATES, M. D.

Alliance, O.

NOTES AND COMMENTS.

Invitation to the International Medico-Scientific Exhibition.

In connection with the Tenth International Medical Congress, to be held in Berlin, August 4-9, 1890, there will be an International Medico-Scientific Exhibition. The Committee of Organization have been authorized by the representatives of the medical Faculties and the leading medical Societies of the German Empire to make the preliminary arrangements. It therefore cordially invites all who may wish to exhibit or participate in the above Exhibition. All exhibits must be of a scientific nature.

The exhibits expected will be as follows:

1. New or improved scientific instruments for biological or special medical purposes, including apparatus for photography and spectral analysis pertaining to medicine.
2. New pharmacological chemical substances and preparations.
3. New pharmaceutical substances and preparations.
4. New food preparations.
5. New or improved instruments for internal and external medicine, and allied specialties including electrotherapy.
6. Plans and models (new) of hospitals; houses for convalescents, disinfection and general bath-houses.
7. New appliances, such as pertain to nursing the sick, including the methods of transportation, and baths for the sick.

8. Apparatus (new) for hygienic purposes.

The Special Committee on Exhibition consists of the following gentlemen: Commerzienrath Paul Dörfel, H. Haensch, Director Dr. J. F. Holtz, Director Dr. L. Loewenherz, Regierungsrath Dr. J. Petri, H. Windler, and the Secretary-General of the Committee of Organization. The names of the Associate Members of the Exhibition Committee, as well as the names of the Heads of Departments, will be made known shortly, also the conditions for Exhibitors.

For applications for exhibits, and information, address Dr. O. Lassar, Secretary-General, Bureau of the Tenth International Medical Congress, Berlin, N. W., Carlstrasse No. 19.

All mail matter relating to the Exhibition should be marked "Exhibition Affairs," and should enclose a visiting card or card of the firm, on which the name and residence is plainly written or printed.

Meetings of State Medical Societies in 1890.

The following is a list of State Medical Society meetings in 1890.

Alabama, Birmingham, April 8, T. A. Means, Secretary, Montgomery.

Arkansas, Little Rock, May 14, L. P. Gibson, Secretary, Little Rock.

California, Los Angeles, April 15, W. W. Kerr, Secretary, San Francisco.

Colorado, Denver, June 17, H. W. McLauthlin, Secretary, Denver.

Connecticut, New Haven, May 28, N. E. Wordin, Secretary, Bridgeport.

Dakota, Sioux Falls, June 12, R. C. Warne, Secretary, Mitchell.

Delaware, Wilmington, June 10, J. A. Ellegood, Secretary, Laurel.

Florida, Ocala, April 8, J. D. Fernandez, Secretary *pro tem.*, Jacksonville.

Georgia, Brunswick, April 16, King P. Moore, Secretary, Macon.

Illinois, Chicago, May 6, D. W. Graham, Secretary, Chicago.

Indiana, Indianapolis, May 14, E. S. Elder, Secretary, Indianapolis.

Iowa, Des Moines, April 16, C. F. Darrell, Secretary, West Union.

Kansas, Salina, May 13, J. E. Minney, Secretary, Topeka.

Kentucky, Henderson, May 14, Steele Bailey, Secretary, Stanford.

Louisiana, Baton Rouge, May 13, P. B. McCutcheon, Secretary, New Orleans.

Maine, Portland, June 10, C. D. Smith, Secretary, Portland.

Maryland, Baltimore, April 22, G. A. Taneyhill, Secretary, Baltimore.

Massachusetts, Boston, June 10, F. W. Goss, Secretary, Boston.

Michigan, Grand Rapids, May 20, Geo. Duffield, Secretary, Detroit.

Minnesota, St. Paul, June 19, C. B. With-erle, Secretary, St. Paul.

Mississippi, Jackson, April 21, W. E. Todd, Secretary, Jackson.

Missouri, Excelsior Springs, May 6, J. C. Mulhall, Secretary, St. Louis.

Nebraska, Beatrice, May 13, M. L. Hildreth, Secretary, Lyons.

New Hampshire, Concord, June 16, G. P. Conn, Secretary, Concord.

New Jersey, Schooley's Mountain, June 10, W. Pierson, Secretary, Orange.

New York, New York, October 22, E. D. Ferguson, Secretary, Troy.

North Carolina, Oxford, May 27, J. M. Hays, Secretary, Oxford.

Ohio, Columbus, June 3, G. A. Collamore, Secretary, Toledo.

Pennsylvania, Pittsburgh, June 10, W. B. Atkinson, Secretary, Philadelphia.

Rhode Island, Providence, June 12, W. R. White, Secretary, Providence.

South Carolina, Laurens, April, W. P. Porcher, Secretary, Charleston.

Tennessee, Memphis, April 8, D. E. Nelson, Secretary, Chattanooga.

Texas, Fort Worth, April 22, F. E. Daniel, Secretary, Austin.

Vermont, Rutland, June 26, Montpelier, October 9, D. C. Hawley, Secretary, Burlington.

Virginia, Rockbridge Alum Springs, August or September, L. B. Edwards, Secretary, Richmond.

Washington, Spokane Falls, May 14, C. L. Flannigan, Secretary, Olympia.

West Virginia, Wheeling, J. L. Fullerton, Secretary, Charlestown.

Wisconsin, Milwaukee, June 4, J. R. McDill, Secretary, Milwaukee.

Fracture of the Femur in Children.

Dr. J. Howe Adams, in the report of a case of fracture of the femur in a child, in the *University Medical Magazine*, February, 1890, says that simple fractures of the femur

have been regarded by many surgeons as exhibiting the points most characteristic of complete fracture in children. These points are: First, the frequency with which fractures in children are complicated with rickets as a predisposing cause; the transverse direction of the fracture; the slight displacement which may be entirely lacking; the adaptability of apparatus for correction without extension; and the frequency of union without shortening. The periosteum, being thicker and stronger in childhood, is supposed to be accountable for the lack of displacement, resisting successfully outside forces. In rachitis, however, the periosteum is thickened and softened, invalidating the theory in such cases as this; here, probably, the square ends of the bones juttied against each other, overcoming weakened muscular resistance.

Fractures of the femur in children are more common than is generally supposed; all authorities agreeing that the report of M. Coulon is a just estimate. This observer noted at the Hôpital Ste. Eugénie, in one year, 140 fractures in children; 38 of these were of the forearm, and 26 were of the femur; the number of femoral fractures standing second in the order of frequency.

There are many methods of treatment proposed for these fractures in children. Paget, at the St. Bartholomew Hospital, put into practice the idea of using no dressing at all, believing that the restlessness of the little patient prevented the use of extension, and the soiling of immovable dressings by urine and feces made practical difficulties too great to be overcome. This eminent surgeon used no splints, simply "the child being laid on a firm bed, with little or no head-pillow, with the broken limb after setting, is bent at the hip and knee, and laid on its outer side." Mr. Bryant suggests that the fractured and sound limbs be flexed at right angles to the body, fixed with a light splint, and hoisted upward to some support above. Here the weight of the child furnishes a counter-extending force, cleanliness can be insured and a good result expected. Dr. Hamilton advised two long splints, one on each side of the body running nearly to the axilla, with a cross bar at the lower end, making both limbs secure to their respective splints by dressings. The ordinary extension apparatus used for similar fractures in the adult is recommended by many surgeons. The apparatus suggested

by Prof. Agnew in his "Surgery" seems to be the simplest in construction, the easiest in application, and the most rational in idea; it affords sufficient extension, is perfectly firm, and easily kept clean.

A Sanitary Wash-house.

Albert Shaw has a most suggestive paper in the March *Century* entitled "Glasgow; a Municipal Study," from which we quote: "Not the least important feature of the health department's work in Glasgow is the Sanitary Wash-house. A similar establishment should be a part of the municipal economy of every large town. In 1864 the authorities found it necessary to superintend the disinfection of dwellings, and a small temporary wash-house was opened, with a few tubs for the cleansing of apparel, etc., removed from infected houses. For a time after the acquisition of Belvidere a part of the laundry of the hospital was used for the purpose of a general sanitary wash-house. But larger quarters being needed, a separate establishment was built and opened in 1883, its cost being about \$50,000. This place is so admirable in its system and its mechanical appointments that I am again tempted to digress with a technical description. The place is in constant communication with sanitary headquarters, and its collecting wagons are on the road early every morning. The larger part of the articles removed for disinfection and cleansing must be returned on the same day, to meet the necessities of poor families. I visited the house on a day when 1,800 pieces, from 25 different families, had come in. In 1887, 6,700 washings, aggregating 380,000 pieces, were done. The quantity, of course, varies from year to year with the amount of infectious disease in the city. The establishment has a crematory, to which all household articles whatsoever that are to be burned after a case of infectious disease must be brought by the vans of the sanitary department. The carpet-cleaning machinery and the arrangements for disinfection by steam, by chemicals, and by boiling I cannot here describe.

"The department's disinfecting and whitewashing staff is operated from the wash-house as headquarters. A patient being removed to the hospital, the authorities at once take possession of the house for cleansing and disinfection. It is a point of

interest also that the city has provided a comfortable 'house of reception' of some ten rooms, with two or three permanent servants, where families may be entertained for a day or more as the city's guests if it is desirable to remove them from their homes during the progress of the disinfecting and clothes-washing operations. The house is kept in constant use, and it is found a very convenient thing for the department to have at its disposal.

"As net results of the sanitary work of the Glasgow authorities may be mentioned the most entire extinction of some of the worst forms of contagious disease, and a mastery of the situation which leaves comparatively little fear of widespread epidemics in the future, in spite of the fact that Glasgow is a great seaport, has an unfavorable climate, and has an extraordinarily dense and badly housed working population. The steady decline of the total death-rate, and its remarkably rapid decline as regards those diseases at which sanitary science more especially aims its weapons, are achievements which are a proper source of gratification to the town council and the officers of the health department."

Medical College Commencements in 1890.

The following are some of the colleges which held their commencements in February or March, 1890: Atlanta Medical College, Atlanta, Ga., 51 graduates; Bellevue Hospital Medical College, 144 graduates; College of Physicians and Surgeons, Koekuk, Ia., 61 graduates, five of whom were women; Ensworth Medical College, St. Joseph, Mo., 14 graduates; Georgia College of Eclectic Medicine, Atlanta, Ga., 16 graduates, including one woman; Howard University Medical School, Washington, D. C., 26 graduates, one of whom was a woman; Iowa College of Physicians and Surgeons, Des Moines, Ia., 5 male and 2 female graduates; Medical College of Ohio, Cincinnati, 91 graduates; Miami Medical College, Cincinnati, 31 graduates; Pulte Medical College, Cincinnati, 16 graduates; Starling Medical College, Columbus, Ohio, 39 graduates; Woman's Medical College of Pennsylvania, Philadelphia, Pa., 40 graduates; Kansas City Medical College, Kansas City, Mo., 16 graduates; The University of Louisville, 145 graduates; Western Reserve Medical

College, Cleveland, O., 30 graduates; Long Island College Hospital, 57 graduates.

Hypertrophy of the Prostate Gland.

In a paper on the prostate gland, in a recent number of the *Journal of Anatomy and Physiology*, Mr. Griffiths, Assistant to the Professor of Surgery at Cambridge, arrives at the following conclusions: 1. Enlargement or hypertrophy of the prostate gland results from a growth of the gland tubules with their associated muscle, so as to form new gland substance, closely resembling in its structure the normal gland. This constitutes the first or glandular stage. 2. After a variable time degenerative changes set in, which ultimately convert the new tissue into a mass of more or less dense, fibrous, connective tissue, containing only the atrophied remains of the glandular and muscular elements. This constitutes the second or fibrous stage. 3. No enlargement takes place behind the urethra except when glandular substance exists behind and above the level of the veru montanum in the situation of the "third" or median lobe. 4. So-called "tumors" are not in reality tumors, but merely pronounced localized enlargements of the gland, which pass through the same stages as the gland when enlarged as a whole. 5. True muscular tumors (myomata) do sometimes, though rarely, arise in the substance of the prostate gland, but they are pathologically different from the ordinary local or general enlargement of the gland.—*Lancet*, Feb. 15, 1890.

Treatment of Photophobia.

At a recent meeting of the Paris Ophthalmological Society, as reported in *La France Médicale*, M. Guttierier Pouce spoke of a case of keratitis with intense photophobia, in which he had successfully treated that symptom by what he calls "direct anæsthesia of the Gasserian ganglion." This he effected by the simple device of inserting into the external auditory meatus a plug of cotton soaked in chloroform. Such an easy method to carry out in cases of photophobia certainly seems worthy of more extensive trial, and if it proves useful in other cases, it will be a valuable addition to the resources of physicians.

NEWS.

—Dr. Edwin C. Leedom, of Montgomery county, died March 18, aged 85 years.

—A children's dispensary has been opened in connection with the Children's Hospital of the Mary J. Drexel Home, Philadelphia.

—Telegrams from Rio Janeiro, received about March 18, say that yellow fever has broken out in the cities of Campinas and Sao Paulo.

—George D. Rosengarten, who for many years was engaged in the manufacture of fine chemicals, died in Philadelphia, March 18, aged 89 years.

—It is announced that at Richfield Springs a magnificent new bath-house is to be put up at an expense of \$40,000, and that it will provide sulphur and other baths equal to any in Europe.

—Dr. H. Augustus Wilson, professor of general and orthopedic surgery in the Philadelphia Polyclinic and College for Graduates in Medicine, has been elected Lecturer on Orthopedic Surgery at the Woman's Medical College of Philadelphia.

—Dr. Charles J. Nordquist, of Tuckahoe, N. Y., was killed recently by a train on the Harlem Railroad. He was driving from Mount Vernon to his home, and while crossing the track his phaeton was struck by the engine, and he was thrown out and killed.

—The 25th annual commencement of Bellevue Hospital Medical College took place at the Carnegie Laboratory on March 10, and the degree of M. D. was conferred on 144 graduates by the President, Prof. William T. Lusk, who made a brief address to the class.

—The commencement exercises of the Long Island College Hospital were held March 12 at the Brooklyn Academy of Music. Mr. Truman J. Backus, President of the Parker Institute, delivered the address to the fifty-seven graduates, and Rush W. Kimball was the valedictorian.

—About seventy members of the British Medical Association have resigned because they are dissatisfied with the way in which it is being managed by the party now controlling its affairs. The list of resigners includes the names of Thomas Bryant, Ch. Heath, Berkley Hill, Eustace Smith, Edmund Owen, Matthews Duncan and Fredrick Treves.

—Mr. and Mrs. J. Vaughan Merrick of Philadelphia have offered as a gift to the vestry of St. Timothy's Protestant Episcopal

Church, Roxborough, a furnished house containing nineteen rooms, with an acre of land, opposite the church, for a hospital, and \$10,000 as the nucleus of an endowment fund. The gift is to be a memorial to the parents of the donors.

—The name of the donor of the large sum of a hundred thousand pounds for a convalescent home near London has come to light, notwithstanding his wishes to keep in the background; his name is Peter Reid. He has already been prominent for his generous interest in hospitals and other charitable institutions, but his last grand gift to the sick poor of London was announced as from an anonymous source in January last.

—The Society of the Alumni of Bellevue Hospital will hold a decennial reunion on April 8, 9 and 10, in New York. Clinics will be held at the hospital, papers will be read by members at the Mott Memorial Library, and a banquet will be given at the Hotel Brunswick on the evening of the second day. All the former internes have received invitations to attend. Dr. R. J. Carlisle, of No. 58 West Twenty-fifth street, will give information concerning tickets, etc.

—The druggists of Aberdeen, South Dakota, on March 17 signed an agreement to keep no liquors after May 1, and it is believed the agreement will be followed generally throughout the State. They object to the Prohibition act, especially those provisions requiring petitions signed by twenty women necessary to secure permits, the thousand-dollar bond clause and the general "humiliating features of the measure, which are an outrage on reputable druggists."

—It has been announced to the managers of the Moses Taylor Memorial Hospital at Scranton, Pa., that it is the purpose of Mrs. Taylor to contribute an endowment fund of \$250,000, the income of which shall be used for the maintenance of the hospital. Her son, Mr. George Taylor, has given \$50,000 for immediate use upon an unfinished part of the buildings. A daughter, Mrs. Pyne, is already represented by a gift of \$100,000 for construction purposes. Under the will of the late Moses Taylor, a bequest for hospital purposes amounting to \$250,000 was made, making a grand total of \$650,000 from the family, given with the special object of meeting the needs of the employees of the large railroad and mining corporations which have Scranton as their most available centre.